On a minor point, the authors clearly mean, based on context (page 634, column one, last paragraph, first sentence) that the left flank, not the right, is percussed with the patient in the right lateral decubitus position—percussion of the dependent flank would be clumsy and uncomfortable, if not impossible.

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Contact Lenses and Respirator Use

TO THE EDITOR: In the epitome "Use of Personal Respiratory Protective Devices (Respirators)" in the October issue,[1] it is stated that "The use of contact lenses while wearing respirators needs careful consideration." I concur with this as medical advice, since on medical grounds I doubt that it is necessary to automatically exclude contact lenses merely because a respirator is worn. However, I believe it should be pointed out that federal OSHA [Occupational Safety and Health Administration]and state OSHA regulations have definite requirements regarding this point. A physician should always be aware of the legal requirements when extending medical approval or advice regarding respirator use. As an example, Cal-OSHA regulations state the following: "Wearing of contact lenses shall not be permitted in an atmosphere where a respirator is required."[2] This would apparently exclude any medical judgment about the advisability of wearing contact lenses in situations where respirators are worn.

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'Pseudoseptic' Arthritis

TO THE EDITOR: The recent description of "pseudoseptic" arthritis in patients with "rheumatoid" arthritis by Call and co-workers[1] is an important clinical observation. It brings to light yet another complication of rheumatoid arthritis for physicians to recognize. In the past year I have treated a patient with a similar syndrome and I report this case to add to their series.

Report of a Case

The patient, a 77-year-old man who had had rheumatoid arthritis for 23 years, was admitted to hospital six hours after the abrupt onset of a rigor followed by feverishness and arthralgias especially affecting both elbows. He reported that he had had two or three such episodes a year for several years but had never previously sought medical attention. They would generally last one or two days and resolve after self-medication with extra corticosteroids. He had been taking 8 mg of triamcinolone (Aristocort) and enteric-coated aspirin daily for 21 years.

On physical examination he appeared ill. His temperature was 38.7°C (101.8°F). His elbow joints were tender and swollen. No fluid could be aspirated from the right elbow but 4 ml of thick pus was aspirated from the left elbow joint. The synovial fluid had a nucleated cell count of 82,000 cells per μl with 90% polymorphonuclear leukocytes. Gram's stain and crystal analysis of the fluid were negative. The peripheral blood leukocyte count was 14,700 per μl with 70% segmented and 3% band cells. The erythrocyte sedimentation rate was 14 mm per hour. An x-ray study of the affected elbow showed degenerative changes only.

Treatment was begun with intravenously given oxacillin sodium, gentamicin sulfate and increased corticosteroids for presumptive septic arthritis. The patient's fever subsided within 24 hours and he felt well. The joint swelling and tenderness rapidly resolved. On the second day the left joint was reaspirated and only one ml of thinner fluid obtained. Gram's stain of the fluid was again negative. No fluid could be aspirated the third day. By this time cultures of the blood and joint fluid (including anaerobic and chocolate agar cultures) were reported as negative. The parenteral antibiotics were discontinued and cephalosporin was given by mouth for an additional ten days. There were no long-term complications.

The patient reported one similar episode in the ensuing 1½ years. He was recently seen again with exactly the same syndrome. The left elbow had a tense, painful effusion and 7 ml of thick pus was aspirated from this joint. Synovial fluid nucleated cell count was 88,000 cells per μl with 94% polymorphonuclear leukocytes. Again Gram's stain, crystal analysis and cultures of this fluid were negative. The glucose concentration of the fluid was 23 mg per dl. The peripheral blood leukocyte count was 25,200 per μl with a left shift. The erythrocyte sedimentation rate was 10 mm per hour.

The patient was treated with a boost in his oral steroid dosage and the syndrome resolved within 48 hours. No antibiotics were given.

Discussion

This man presented with the typical clinical features of septic arthritis complicating steroid-dependent rheumatoid arthritis. Similar to the patients described by Call and coworkers, there was pus in the joint compatible with bacterial arthritis but crystal studies, Gram's stains and cultures were negative. The rapid resolution of systemic and joint symptoms and signs is unlike true septic arthritis. Interestingly, this patient has experienced documented recurrent episodes as had one patient in the report by Call and associates.

In contrast to the generally poor outcome seen with bacterial arthritis in patients with rheumatoid arthritis,[2] none of the patients with "pseudoseptic" arthritis suffered any excessive morbidity or further joint destruction. Although disseminated gonococcal infection, Reiter's syndrome, gout and pseudogout can all present with a culture-negative arthritis with intense synovial leukocytosis, each has distinct clinical fea-